RAI ASSESSMENT SCHEDULE SUMMARY

Record Type	Completion	Care Plan Completion (VB4)	Submit to State by No Later Than:
Admission	By VB2, no later than Day 14.	VB2 + 7 Days	VB4 + 31 Days
Annual Assessment	Completed within 366 days of most recent comprehensive assessment (VB2 to VB2).	VB2 + 7 Days	VB4 + 31 Days
Significant Change in Status	Must be completed by the end of the 14th calendar day following determination that a significant change has occurred.	VB2 + 7 Days	VB4 + 31 Days
Significant Correction of Prior Full Assessment	Must be completed within 14 days of identification of a major, uncorrected error in a prior comprehensive assessment.	VB2 + 7 Days	VB4 + 31 Days
Quarterly	R2b, no later than 14 days after the A/RD, 92 days from R2b to R2b.	N/A	R2b + 31 Days
Significant Correction of Prior Quarterly Assessment	Must be completed within 14 days of the identification of a major, uncorrected error in a prior Quarterly assessment.	N/A	R2b + 31 Days
Discharge Tracking Form	Date of Event at R4 + 7 Days	N/A	R4 + 31Days
Reentry Tracking Form	Date of Event at A4a + 7 Days	N/A	A4a + 31 Days
Correction Request Form	Date at AT6, no later than 14 days after detecting an inaccuracy in an MDS record that has been accepted in State MDS database.	N/A	AT6 + 31 Days

MEDICARE MDS ASSESSMENT SCHEDULE FOR SNFs

Codes for Assessments Required for Medicare	Assessment Reference Date (ARD) Can be set on any of following days	GRACE PERIOD DAYS ARD can also be set on these days	BILLING CYCLE Used by the business office	SPECIAL COMMENT
5 DAY AA8b = 1 AND Readmission/ Return AA8b = 5	Days 1-5	6-8	Set payment rate for Days 1-14	• If a resident transfers or expires before the Medicare 5-Day assessment is finished, prepare an MDS as completely as possible for the RUG Classification and proper Medicare payment, or bill at the default rate. • RAPS must be completed only if the Medicare 5-Day assessment is dually-coded as an Admission assessment or SCSA.
14 Day AA8b = 7	Days 11-14	15-19	Set payment rate for Days 15-30	• RAPs must be completed only if the 14-Day assessment was dually coded as an Admission or Significant Change in Status assessment. • Grace period days do not apply when RAPs are required on a dually coded assessment, e.g., Admission assessment.
30 Day AA8b = 2	Days 21-29	30-34	Set payment rate for Days 31-60	
60 Day AA8b = 3	Days 50-59	60-64	Set payment rate for Days 61-90	
90 Day AA8b = 4	Days 80-89	90-94	Set payment rate for Days 91-100	• Be careful when using grace days for a Medicare 90-Day assessment. The completion date of the Quarterly (R2b) must be no more than 92 days after the R2b of the prior OBRA assessment.
Other Medicare Required Assessment (OMRA)	• 8 - 10 days after all therapy (PT, OT, ST) services are discontinued and resident continues to require skilled care. • The first non-therapy day counts as day 1.	N/A	Set payment rate effective with the ARD	• Not required if the resident has been determined to no longer meet Medicare skilled level of care. • Establishes a new non-therapy RUG Classification. • Not required if the resident is discharged from Medicare prior to day 8. • Not required if not previously in a RUG-III Rehabilitation Plus Extensive Services or Rehabilitation group
Significant Change in Status Assessment (SCSA)	Completed by the end of the 14th calendar day following determination that a significant change has occurred.	N/A	Set payment rate effective with the ARD	• Could establish a new RUG Classification and remains effective until the next assessment is completed.

***NOTE**: Significant Correction assessments are not required for Medicare assessments that have not been combined with an OBRA assessment. See Chapter 5 for detailed instructions on the correction process.

P4. Physical Restraints (7-day look back)

Intent: To record the frequency, over the last seven days, with which the resident was restrained by any of the devices listed below at any time during the day or night. The intent is to evaluate as part of the assessment process whether or not a device meets the definition of a physical restraint, and then to code only those devices categorized in section P4 that have the effect of restraining the resident.

Definition: Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

a. **Full Bed Rails** - Full rails may be one or more rails along both sides of the resident's bed that block three-quarters to the whole length of the mattress from top to bottom. This definition also includes beds with one side placed against the wall (prohibiting the resident from entering and exiting on that side) and the other side blocked by a full rail (one or more rails). Include in this category veil screens (used in pediatric units) and enclosed bed systems.

b. **Other Types of Bed Rails Used** - Any combination of partial rails (e.g., 1/4, 1/3, 1/2, 3/4, etc.) or combination of partial and full rails not covered by the above "full bed rail" category (e.g., one-side half rail, one-side full rail, two-sided half rails, etc.)

c. **Trunk Restraint** - Includes any device or equipment or material that the resident cannot easily remove (e.g., vest or waist restraint, belts used in wheelchairs).

d. **Limb Restraint** - Includes any device or equipment or material that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm) or lower extremity (i.e., foot, leg). Include in this category mittens.

e. **Chair Prevents Rising** - Any type of chair with locked lap board or chair that places resident in a recumbent position that restricts rising or a chair that is soft and low to the floor. Include in this category enclosed framed wheeled walkers with or without a posterior seat and lap cushions that a resident cannot easily remove.

Process: Check the resident's clinical records. Consult nursing staff. Observe the resident. To determine whether or not an item is a physical restraint, the assessor should evaluate whether or not the resident can easily remove the device, material or equipment. If the resident cannot easily remove the item, continue with the assessment to determine whether or not the device meets the other provisions in the definition of a physical restraint. The assessor should not focus on the intent or reason behind the use of the device, but on the effect the device

has on the resident. Does the device, material, or equipment meet the definition of a physical restraint? If yes, code the item in the appropriate category.

Coding: For each device type, enter:

0. Not used in last 7 days

1. Used, but used less than daily in last 7 days

2. Used on a daily basis in last 7 days

Because the coding categories are limited, we have given some direction on which category to code particular devices. While the device may not be completely representative of the category description, follow the coding instruction as given. There may be devices that we have not given coding instructions for and there is not a category that is representative of the device. For those devices, do not code at this time, but note that in subsequent versions of the MDS, CMS will include an "other" category that would be an appropriate place to code these devices. **NOTE**: Any device, material or equipment that meets the definition of a physical restraint must have: a medical symptom that warrants the use of the restraint; a physician's order for use; and must be care planned whether or not there is a category to code the physical restraint on the MDS.

Exclude from this P4 section items that are typically used in the provision of medical care, such as catheters, drainage tubes, casts, traction, leg, arm, neck or back braces, abdominal binders and bandages that are serving in their usual capacity to meet medical need.

Clarifications:

- Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by restraints. It is vital that restraints used on this population be carefully considered and monitored. In some cases, the risk of using the device may be greater than the risk of not using the device.

- Should enclosed framed wheeled walkers, with or without a posterior seat, such as the Merry Walker® Ambulation Device and other devices like it, be coded in section P4e: "Chair prevents rising?"

  As will be set forth in the guidance to surveyors, the Merry Walker® Ambulation Device and similar devices should not be categorically classified as a restraint. The following coding information provides further detailed guidance on how to code utilization of the device that might for a particular resident be considered a restraint. If these devices assist ambulation for a particular resident, they should be coded as a cane/walker/crutch at Item G5a, whether or not they are coded as a restraint.

(1) **Coding When Not a Restraint**

If a resident is able to easily open the front gate and exit the device, the device should **not** be coded as a restraint for this particular resident. It would be coded at Item G5a as a Cane/walker/crutch.

(2) **Coding When a Restraint**

(a) Only if the device has the effect of restricting the resident's freedom of movement, should the device be considered a restraint. If the resident's freedom of movement is restricted because the resident cannot open the front gate and exit the device (due to cognitive or physical limitations that prevents him or her from exiting the device), then the device should be coded as a restraint in Item P4 of the MDS.

(b) The current version of the MDS (Version 2.0) does not contain a category for a restraint in which this device obviously falls. We understand that these devices do not prevent a resident from standing. Nevertheless, until CMS releases the next version of the MDS, when the device restricts freedom of movement, code the device at Item P4e, Chair prevents rising, with either a "1" (Used less than daily), or a "2" (Used daily). In subsequent versions of the MDS, CMS will include an "other" category, which would be an appropriate place to code this type of device.

(c) Coding the device at Item P4e does not preclude the facility from also coding the device at Item G5a (Cane/walker/crutch) if the resident used the device to walk during the last 7 days.

Request for Restraints:

While a resident, family member, legal representative or surrogate may request that a restraint be used, the facility has the responsibility to evaluate the appropriateness of that request, as they would a request for any type of medical treatment. As with other medical treatments, such as the use of prescription drugs, a resident, family member, legal representative or surrogate has the right to refuse treatment, but not to demand its use when it is not deemed medically necessary. According to the Code of Federal Regulation (CFR) at 42 CFR 483.13(a), "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms." CMS expects that no resident will be restrained for discipline or convenience. Prior to employing any restraint, the nursing facility must perform a prescribed resident assessment to properly identify the resident's needs and the medical symptom the restraint is being employed to address. The guidelines in the State Operations Manual (SOM) state, "...the legal

surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of regulation solely based on a legal surrogate or representative's request or approval." The SOM goes on to state, "While Federal regulations affirm the resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate or representative to demand that the facility use specific medical intervention or treatment that the facility deems inappropriate. Statutory requirements hold the facility ultimately accountable for the resident's care and safety, including clinical decisions."

Are Restraints Prohibited?

The regulations and CMS' guidelines do not prohibit the use of restraints in nursing facilities, except when they are imposed for discipline or convenience and not required to treat the resident's medical symptoms. The regulation states, "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms" (42 CFR 483.13(a)). Research and standards of practice show that the belief that restraints ensure safety is often unfounded. In practice, restraints have many negative side effects and risks that, in some cases, far outweigh any possible benefit that can be derived from their use. Prior to using any restraint, the facility must assess the resident to properly identify the resident's needs and the medical symptom that the restraint is being employed to address. If a restraint is needed to treat the resident's medical symptom, the facility is responsible to assess the appropriateness of that restraint. When the decision is made to use a restraint, CMS encourages, to the extent possible, gradual restraint reduction because there are many negative outcomes associated with restraint use. While a restraint-free environment is not a Federal requirement, the use of restraints should be the exception, not the rule.

Bed Rails Used as Positioning Devices:

In classifying any device as a restraint, the assessor must consider the effect the device has on the individual, not the purpose or intent of its use. It is possible for a device to improve the resident's mobility and also have the effect of restraining the individual. **If the side rail has the effect of restraining the resident and meets the definition of a physical restraint for that individual, the facility is responsible to assess the appropriateness of that restraint**. Prior to employing any restraint, the facility must assess the resident to properly identify the resident's needs and the medical symptom the restraint is being employed to address. When the facility decides that a restraint is needed to treat the resident's medical symptom, CMS encourages, to the extent possible, gradual restraint reduction because of the many negative outcomes associated with restraint use. While

bed rails may serve more than one function, the assessor should code Items P4a or P4b when the bed rails meet the definition of a restraint. When a bed rail is *both* a restraint *and* a transfer or mobility aid, it should be coded at Item P4 (a or b, as appropriate) *and* at Item G6b (Bedrails used for mobility or transfer).

Devices Used with Residents Who Are Immobile:

Side Rails - Physical restraints are defined as "any manual method, physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily that restricts freedom of movement or normal access to one's body." If the resident is immobile and can not voluntarily get out of bed due to a physical limitation and not due to a restraining device or because proper assistive devices were not present, the bed rails do not meet the definition of a restraint.

For residents who have no voluntary movement, the staff needs to determine if there is any appropriate use of bed rails. Bed rails may create a visual barrier and deter physical contact from others. Some residents have no ability to carry out voluntary movements, yet they exhibit involuntary movements. Involuntary movements, resident weight, and gravity's effects may lead to the resident's body shifting towards the edge of the bed. For this type of resident, clinical evaluation of alternatives (e.g., a concave mattress to keep the resident from going over the edge of the bed), coupled with frequent monitoring of the resident's position, should be considered. While the bed rails may not constitute a restraint, they may affect the resident's quality of life and create an accident hazard.

Geriatric Chairs - For a resident who has no voluntary or involuntary movement, the geriatric chair does not meet the definition of a restraint and should not be coded at Item P4e. If the resident has the ability to transfer from other chairs, but cannot transfer from a geriatric chair, a geriatric chair is a restraint to that individual, and should be coded at Item P4e. If the resident has no ability to transfer independently, then the geriatric chair does not meet the definition of a restraint, and should not be coded at Item P4e.

P5. Hospital Stay(s) (90-day look back)

Intent: To record how many times the resident was admitted to the hospital with an overnight stay in the last 90 days or since the last assessment if less than 90 days [regardless of payment status for these days either by the hospital or by the nursing facility]. If the resident is a new admission to the facility, this item includes admissions during the period prior to admission.

In summary, the facility must then take the following actions:

1. Correct the original assessment,
2. Submit the corrected assessment, and
3. Perform a Significant Correction of a Prior assessment or Significant Change in Status assessment if the error was major, and update the care plan as necessary.

If the MDS (MPAF) is performed for Medicare purposes only (AA8a = 00, AA8b = 1, 2, 3, 4, 5, 7 or 8), no Significant Change in Status or Significant Correction of a Prior assessment is required. RAPs and care planning are not required with Medicare assessments.

5.6 Correcting Errors in MDS Records That Have Been Accepted Into The State MDS Database

Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item coding errors or other errors. Two processes have been established to correct MDS records (assessments or tracking forms) that have been accepted into the State MDS database:

- **Modification**
- **Inactivation**

A Modification request moves the inaccurate record into the history file in the State MDS database and replaces it with the corrected record in the active database. An Inactivation request also moves the inaccurate record into the history file in the State MDS database, but does not replace it with a new record. Both the Modification and Inactivation processes require an MDS Correction Request form.

The MDS Correction Request form (Prior Record Section and Section AT) contains the minimum amount of information necessary to enable correction of the erroneous MDS data previously submitted and accepted into the State MDS database. A hard copy of the Correction Request form must be kept with the corrected paper copy of the MDS record in the clinical file to track the changes made with the modification. A hard copy of the Correction Request form should also be kept with an inactivated record. (A copy of the Correction Request form can be found at the end of this chapter.)

Detailed instructions concerning completion of the Correction Request form and examples of the correction process are included in the final Provider Instructions for Making Automated Corrections Using the New MDS Correction Request Form (September, 2000), which may be accessed at http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp.

MODIFICATION REQUESTS

A Modification request should be used when a **valid** MDS record (assessment or tracking form) is in the State MDS database, but the information in the record contains errors. A record is considered to be valid if it meets all of the following conditions:

1. It is not a test record.
2. The record corresponds to an actual event.
3. The record identifies the correct resident.
4. The record identifies the correct reasons for assessment.
5. The facility has State or Federal authority to submit the record (i.e., the record meets the SUB_REQ submission requirements described in Section 5.1).

When an error is discovered in a tracking form, the facility must complete the following actions to correct the form:

1. Correct the original tracking form,
2. Complete a Correction Request form to modify the tracking form, and
3. Submit the correction record.

When an error is discovered in an assessment, the facility must decide whether or not it is a major error. If it is not a major error, or if this was an assessment completed only for Medicare purposes, the facility must complete the following actions to correct the assessment:

1. Correct the original assessment,
2. Complete a Correction Request form to modify the assessment, and
3. Submit the correction record.

When a major error is discovered in an assessment after the assessment has been accepted into the State MDS database, the facility must complete the following actions to correct the assessment:

1. Correct the original assessment,
2. Complete a Correction Request form to modify the assessment,
3. Submit the correction record, and
4. Perform a Significant Correction of a Prior assessment or Significant Change in Status assessment and update the care plan as necessary.

When errors identified in a prior assessment have been corrected in a more current assessment, the facility is not required to perform a new comprehensive assessment. In this situation, the facility has already incorporated the accurate data into the care planning process. However, the facility must use the Modification process to assure that the erroneous assessment residing in the State MDS database is corrected.

Generally, most errors may be corrected through the Modification or Inactivation request submitted with a correction record. Minor errors, such as the misspelling of an occupation in Item AB6, do not need to be corrected; they should be noted and corrected with the next assessment.

INACTIVATION REQUESTS

Records must be inactivated when an incorrect reason for assessment has been submitted in either the Primary Reason for Assessment (AA8a) or Medicare Reason for Assessment (AA8b). The record must then be resubmitted with the correct reason(s) for assessment.

An Inactivation should also be used when an **invalid** record has been accepted into the State MDS database, since it moves the inactive record into the history file in the database. Examples of invalid records include the following situations:

1. It was a test record inadvertently submitted as production.
2. The event did not occur; e.g., the record submitted does not correspond to any actual event. For example, a discharge tracking form was submitted for a resident but there was no actual discharge. There was no event.
3. The record submitted identifies the wrong resident. For example, a discharge tracking form was completed and submitted for the wrong person.
4. The record submitted identifies the wrong reasons for assessment. For example, a Reentry Tracking form was submitted when the resident was discharged.
5. Inadvertent submission of an inappropriate, non-required record, such as a non-standard assessment performed for "in-house" quality improvement or quality assurance programs.

When inactivating a record, the facility is required to submit an electronic record.

5.7 Inactivation of Submitted Records Lacking State or Federal Authority

Submission of MDS assessment records to the MDS standard database constitutes a release of private information and must conform to privacy laws. The facility indicates the submission authority for a record in a field labeled SUB_REQ. (See Section 5.1)

SUB_REQ may not be modified with a normal MDS modification request. The formal Inactivation process is also insufficient, since the inappropriately submitted record would still remain in the database in the history file. If the SUB_REQ value is incorrect on a record already accepted into the standard MDS database, the facility must make a request to the State help desk to evaluate the problem and, if appropriate, the MDS database will be manually corrected.

Numeric Identifier: _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT/TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	a. (First) b. (Middle initial) c. (Last) d. (Jr/Sr)
2.	GENDER	1. Male 2. Female
3.	BIRTHDATE	Month – Day – Year
4.	RACE/ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY AND MEDICARE NUMBERS (X in 1st box if non-med. no.)	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO.	a. State No. b. Federal No.
7.	MEDICAID NO. ["x" if pending, "N" if not a Medicaid recipient]	
8.	REASONS FOR ASSESSMENT	[Note—Other codes do not apply to this form] a. Primary reason for assessment: 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. NONE OF ABOVE b. Codes for assessments required for Medicare PPS or the State: 1. Medicare 5 day assessment 2. Medicare 30 day assessment 3. Medicare 60 day assessment 4. Medicare 90 day assessment 5. Medicare readmission/return assessment 6. Other state-required assessment 7. Medicare 14 day assessment 8. Other Medicare-required assessment

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form		
I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.		
Signature and Title	Section	Date
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		
i.		
j.		
k.		
l.		

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

© = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter ☐ a. = When letter in box, check if condition applies